



MARICOPA COUNTY

RETIREE HEALTH INSURANCE BENEFIT ENROLLMENT/CHANGE FORM

REASON FOR COMPLETING FORM & RETIREE INFORMATION (Please Print)

<input type="checkbox"/> New Retiree Retirement Date: _____ Length of service with Maricopa County Years: _____ Months: _____						
<input type="checkbox"/> Expiration of COBRA Coverage Date COBRA Coverage ended: _____		<input type="checkbox"/> Open Enrollment Name/Address Change		<input type="checkbox"/> Attained Medicare Eligibility		<input type="checkbox"/> Cancel Retiree <input type="checkbox"/> Cancel Dependent
Retiree's Social Security Number		Do you have or are you requesting an Alternative Identification Number?			Medicare Information It is recommended that all Medicare eligible participants enroll & maintain coverage with Medicare Part A and B.	
Retiree's Last Name		First Name	MI	DOB	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> I do not have Medicare <input type="checkbox"/> I have Medicare Part A <input type="checkbox"/> I have Medicare Part B Please attach copy of Medicare Card
Mailing Address					City	State Zip Code
Home Phone #			Other Contact Phone #			Email Address

RETIREMENT SYSTEM INFORMATION (Check One)

<input type="checkbox"/> Arizona State Retirement System	<input type="checkbox"/> Elected Officials' Retirement Plan
<input type="checkbox"/> Public Safety Personnel Retirement System	<input type="checkbox"/> Correction Officer Retirement Plan

SPOUSE INFORMATION (Complete only if adding or dropping a spouse to the retiree's medical or dental plan)

<input type="checkbox"/> Add <input type="checkbox"/> Drop	Social Security #	Provider # (Only if adding spouse)			Medicare Information It is recommended that all Medicare eligible participants enroll & maintain coverage with Medicare Part A and B.	
Last Name	First Name	MI	DOB	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> I do not have Medicare <input type="checkbox"/> I have Medicare Part A <input type="checkbox"/> I have Medicare Part B Please attach copy of Medicare Card	

OTHER DEPENDENT INFORMATION (Complete only if adding or dropping a dependent child to the retiree's medical or dental plan)

Action	Social Security #	Last Name	First Name	Relationship	DOB	Sex	Provider # (If adding)
<input type="checkbox"/> Add <input type="checkbox"/> Drop							
<input type="checkbox"/> Add <input type="checkbox"/> Drop							

Residency Requirement	Non-Emergency Medical Care Service Area	MEDICAL PLAN CHOICE for Retiree (Check One)		
Must reside/ work in Maricopa County	Must receive services in Maricopa County (No non-emergent out-of-network coverage)	<input type="checkbox"/> CIGNA HealthCare for Seniors	<input type="checkbox"/> Maricopa Senior Select Plan (MSSP) Not accepting new enrollments at this time	<input type="checkbox"/> CIGNA Health Maintenance Organization (HMO)
Must reside in AZ	Must receive non-emergent in-network services in AZ	<input type="checkbox"/> CIGNA Point of Service (POS)		
Must reside in US	Must receive services in Maricopa County (No non-emergent out-of-network coverage)	<input type="checkbox"/> HealthSelect		
Must reside in the US	May receive in-network services nationally	<input type="checkbox"/> CIGNA Preferred Provider Organization (PPO)		

MEDICAL PLAN CHOICE for Dependent(s) (Check One)

<input type="checkbox"/> CIGNA HMO	<input type="checkbox"/> CIGNA POS	<input type="checkbox"/> CIGNA PPO	<input type="checkbox"/> HealthSelect	<input type="checkbox"/> CIGNA HealthCare for Seniors
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UNITED CONCORDIA DENTAL PLAN CHOICE for Retiree and Dependents (Check One)

<input type="checkbox"/> Add <input type="checkbox"/> Drop	<input type="checkbox"/> Retiree	<input type="checkbox"/> Retiree & Spouse	<input type="checkbox"/> Retiree & Child(ren)	<input type="checkbox"/> Retiree & Family
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COORDINATION OF BENEFIT INFORMATION FOR MEDICAL PLAN (must provide other non-County insurance coverage information)

Member Name	Medical Plan Name	Plan Address	Plan Phone #	I.D.#	Group #	Effective Date

SPACE BELOW IS FOR OFFICE USE ONLY

RETIREMENT SYSTEM		MARICOPA COUNTY	
Employer code 07		CIGNA	Health Select
<input type="checkbox"/> Maricopa County Rate Code: _____	<input type="checkbox"/> Retirees (NPRET)	<input type="checkbox"/> Over 65 (NPRO65)	<input type="checkbox"/> Under 65 (PRU)
<input type="checkbox"/> Monthly Premium: _____	<input type="checkbox"/> Under 65 (NPRU65)	<input type="checkbox"/> HMO (NPRCOM)	<input type="checkbox"/> Over 65 (PRO)
ASRS Effective Date: _____ Validation: _____			
Retirement System Effective Date: _____ Validation: _____	Maricopa County Effective Date: _____ Validation: _____		

MARICOPA COUNTY

RETIREE HEALTH INSURANCE BENEFIT ENROLLMENT/CHANGE FORM

INSTRUCTIONS: Please print. This form must be completed and signed by the retiree and their covered spouse. Return form and any attachments to Maricopa County Employee Health Initiatives Division, Benefits Office, 301 W. Jefferson, Suite 201, Phoenix AZ 85003. Please call the Benefits Office at 602-506-1010, if you have questions.

REASON FOR COMPLETING FORM & RETIREE INFORMATION

Check the appropriate box indicating the reason for completing this form. If it is due to making an open enrollment change, submit the form to the Benefits Office no later than the closing date of open enrollment. If it is because of a change in status, check the applicable box or state the reason in the Other area. Examples of changes include marriage, divorce, death or attaining Medicare eligibility. Submit the form with to the Benefits Office within thirty-one days of the date of the change. If the retiree longer wants coverage, check the Canceling Insurance box and check the withdrawal statement in the Statement of Understanding section at the bottom of this page. Please note, once coverage is cancelled in the Maricopa County Retiree Health Insurance Benefit Plan, re-enrollment will not be permitted. Lastly, include demographic, Medicare and contact information regarding the retiree.

RETIREMENT SYSTEM INFORMATION

Check the retirement system in which the retiree participates.

SPOUSE INFORMATION

Complete this section with demographic and Medicare information, if you are adding or dropping medical or dental coverage for the retiree's spouse. If adding a spouse, include the provider identification number for all medical plan choices, except for PPO.

OTHER DEPENDENT INFORMATION

Complete this section with demographic information, if you are adding or dropping medical or dental coverage for the retiree's dependent child(ren). If adding a dependent, include the provider identification number for all medical plan choices, except for PPO.

MEDICAL PLAN CHOICES FOR RETIREE

Choose a medical insurance product. Please note, some products have specific residency requirements and restrictions on where medical services will be rendered. If the retiree is enrolling in CIGNA HealthCare for Seniors product, this form must be completed and returned it to the Benefits Office so they can notify and coordinate the premium payment with the appropriate retirement system. The retiree must also contact CIGNA at 1-800-592-9231 to complete the required HealthCare for Seniors enrollment form. The retiree must be enrolled in Medicare Parts A & B and reside in Maricopa County to enroll in this product. If the retiree selects the CIGNA HealthCare for Seniors plan, the dependents may only select the CIGNA HMO plan. Please note that the Maricopa Senior Select Plan (MSSP) is not accepting new enrollments at this time. If your are enrolling in HealthSelect or CIGNA HMO, POS or PPO and are enrolled in Medicare, please attach a copy of the retiree's and/or dependent's Medicare card.

MEDICAL PLAN CHOICES FOR DEPENDENTS

Choose a medical insurance product for the Retiree, spouse and dependent(s). If the dependent spouse selects the CIGNA HealthCare for Seniors plan, the retiree and other dependents may enroll in any products including CIGNA HMO, POS, PPO and HealthSelect.

DENTAL PLAN CHOICES FOR RETIREE AND DEPENDENTS

Choose the level of coverage for the retiree and the retiree's dependents.

COORDINATION OF BENEFIT INFORMATION FOR MEDICAL PLAN

If the retiree or the retiree's dependents are covered under another medical insurance plan, provide the name of the insurance plan/company, address, phone number, identification number, group number and the effective date of coverage. If additional space is required, please attach the remaining information on an additional sheet of paper.

STATEMENT OF UNDERSTANDING

Please read the following statement, check the box indicating that you have done so and sign the form.

I certify that all of my statements on the form are true. I authorize deductions from my retirement pension check by the appropriate Retirement System to cover the premium due for the medical benefits I have chosen. I understand that Maricopa County policy requires that my retiree pension benefit be sufficient to cover the cost of my insurance premium in order to maintain eligibility as a participant in the Maricopa County Retiree Medical Plan. I understand that the premiums may be revised periodically. I also understand that I am responsible to verify the insurance deduction withheld on my pension check is correct. If there is an error in my deduction, I will contact Employee Benefits at 602-506-1010 within 30 days.

By submitting my open enrollment request or continuing with my current health care coverage, I understand and agree that Maricopa County may share protected health information (PHI) concerning me and my dependents as described in the Maricopa County Notice of Privacy Practices, with my health care providers, which could include, CIGNA, HealthSelect, Walgreens Health Initiatives (WHI), United Behavioral Health (UBH), United Concordia, Employers Dental Service (EDS), UnumProvident, AVESIS, Application Software Inc. (the flexible spending account administrator) and WHI in its role as Pharmacy Benefits Manager. I further agree to release Maricopa County and Maricopa County's health care providers from any liability for any good faith release of PHI in connection with my benefits or as otherwise authorized or required by law.

The County will not permit coverage in the retiree medical plan on a direct pay basis. If your pension benefit is not sufficient to cover the cost of your coverage, you will be dis-enrolled from the Maricopa County Retiree Health Insurance Benefit program.

Please note that the retiree health insurance program is an optional program offered by Maricopa County and does not constitute an ongoing promise of coverage. Maricopa County, in its discretion, may discontinue any and all healthcare coverage at any time.

Employees enrolled in a Maricopa County sponsored COBRA medical plan may enroll in the County sponsored retiree health insurance plan upon expiration of their COBRA coverage. There may be no break in coverage period.

- ☐ I have read the Statement of Understanding of this form and request enrollment in the Maricopa County Retiree Insurance Benefit Plan as shown.
- ☐ I withdraw from medical coverage effective _____. By withdrawing, I understand that I am no longer eligible to participate in the medical or dental insurance offered though Maricopa County.

RETIREE'S SIGNATURE: _____

DATE: _____

COVERED SPOUSE'S SIGNATURE: _____

DATE: _____